National Practitioner Data Bank
Healthcare Integrity and Protection Data Bank
P.O. Box 10832
Chantilly, VA 20153−0832

http://www.npdb-hipdb.hrsa.gov

For authorized use by:
TEST ENTITY

MEDICAL MALPRACTICE PAYMENT REPORT

Report Number 7920000036407800

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A. REPORTING ENTITY

Entity Name: TEST ENTITY
Address: 6220 TEST STREET
City, State, ZIP: TEST CITY, VA 11111
Entity Internal Report Reference (e.g., claim number): ENTREF−1011011
Name or Office: TEST POC
Title or Department: TESTING DEPARTMENT
Telephone: (111)222−3333
Type of Report: MMPR Initial Report

B. SUBJECT IDENTIFICATION INFORMATION (INDIVIDUAL)

Subject Name: TEST2LNAME, TEST2FNAME TEST2MNAME JR
Other Name(s) Used:
Gender: FEMALE
Organization Name: TEST2ORGANIZATIONNAME
Work Address: TESTSTREET
City, State, ZIP: TESTCITY, SC 38945
Country:
Home Address:
City, State, ZIP:
Country:
Social Security Numbers (SSN): 532−46−5675
Date of Birth: 05/05/1975
Deceased: UNKNOWN
Date of Death:
Professional School(s) & Year(s) of Graduation: NEW TEST SCHOOL 2000
Occupation/Field of Licensure (Code): NURSE ANESTHETIST (110)
State License Number, State of Licensure: 89768976, CA
Other, as Specified:

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Drug Enforcement Administration (DEA) Numbers: 978678968976

Hospital Affiliation(s):

C. INFORMATION REPORTED

Date of Report: 03/21/2005

Relationship of Entity to This Practitioner: INSURANCE COMPANY − PRIMARY INSURER

PAYMENTS BY THIS PAYER FOR THIS PRACTITIONER

Amount of This Payment for This Practitioner: $200.00

Date of This Payment: 12/02/2002

This Payment Represents: A SINGLE FINAL PAYMENT

Total Amount Paid or to Be Paid by This Payer for This Practitioner: $200.00

Payment Result of: PAYMENT PRIOR TO SETTLEMENT

Date of Judgment or Settlement, if Any:

Adjudicative Body Case Number:

Adjudicative Body Name:

Court File Number:

Description of Judgment or Settlement and Any Conditions, Including Terms of Payment: DESCRIPTION OF JUDGMENT OR SETTLEMENT

PAYMENTS BY THIS PAYER FOR OTHER PRACTITIONERS IN THIS CASE

Total Amount Paid or to Be Paid by This Payer for All Practitioners in This Case:

Number of Practitioners for Whom This Payer Has Paid or Will Pay in This Case:

PAYMENTS BY OTHERS FOR THIS PRACTITIONERS

Has a State Guaranty Fund or State Excess Judgment Fund Made a Payment for This Practitioner in This Case, or Is Such a Payment Expected to Be Made?: UNKNOWN

Amount Paid or Expected to Be Paid by the State Fund:

Has a Self−Insured Organization and/or Other Insurance Company/Companies Made Payment(s) for This Practitioner in This Case, or Is/Are Such Payment(s) Expected to Be Made?: UNKNOWN

Amount Paid or Expected to Be Paid by Self−Insured Organization(s) and/or Other Insurance Company/Companies:

CLASSIFICATION OF ACT(S) OR OMISSION(S)

Patient's Age at Time of Initial Event:	10 MONTH(S)
Patient's Gender:	FEMALE
Patient Type:	UNKNOWN
Description of the Medical Condition With Which the Patient Presented for Treatment:	DESCRIPTION OF THE MEDICAL CONDITION
Description of the Procedure Performed:	DESCRIPTION OF THE PROCEDURE PERFORMED
Nature of Allegation:	MONITORING RELATED (070)
Specific Allegation:	FAILURE TO TREAT FETAL DISTRESS (104)
Other Specific Allegation:	
Date of Event Associated With Allegation or Incident:	12/02/2001
Specific Allegation:	
Other Specific Allegation:	
Date of Event Associated With Allegation or Incident:	
Outcome:	MINOR TEMPORARY INJURY (03)
Description of the Allegations and Injuries or Illnesses Upon Which the Action or Claim Was Based:	DESCRIPTION OF THE ALLEGATIONS AND INJURIES OR ILLNESSES

D. SUBJECT STATEMENT

If the subject identified in Section B of this report has submitted a statement, it appears in this section.

Date Submitted: 03/21/2005

I am the subject. This is my statement.

E. REPORT STATUS

Unless one or more boxes below are checked, the subject of this report identified in Section B has not contested this report.

☐ If box is checked, this report has been disputed by the subject identified in Section B.

☒ If box is checked, at the request of the subject identified in Section B, this report is being reviewed by the Secretary of the U.S. Department of Health and Human Services to determine its accuracy and/or whether it complies with reporting requirements. No decision has been reached.

☐ If box is checked, at the request of the subject identified in Section B, this report was reviewed by the Secretary of the U.S. Department of Health and Human Services. The Secretary's decision is shown below:

Date of Initial Report: 03/21/2005

Date of Most Recent Change: 03/21/2005

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F. SUPPLEMENTAL SUBJECT INFORMATION ON FILE WITH DATA BANKS

The following information was not provided by the reporting entity identified in Section A of this report. The information was submitted to the Data Banks from other sources and is intended to supplement the information contained in this report.

Subject Name(s): TESTALTLNAME, TESTALTFIRST TESTALTMID
TESTALTERNATELASTNAME, TESTALTFIRSTNAM
TESTALTMIDNAME JR

END OF REPORT